HUMAN SERVICES

(a)

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

Managed Health Care Services for Medicaid/NJ FamilyCare Beneficiaries

Readoption with Amendments: N.J.A.C. 10:74

Adopted Repeals: N.J.A.C. 10:74-3.6, 3.7, 3.8, and 8.4

Proposed: April 1, 2019, at 51 N.J.R. 452(a).
Adopted: July 22, 2019, by Carole Johnson, Commissioner, Department of Human Services.
Filed: July 23, 2019, as R.2019 d.088, **with non-substantial changes** not requiring additional public notice and comment (see N.J.A.C. 1:30-6.3).

Authority: N.J.S.A. 30:4D-1 et seq., and 30:4J-8 et seq.

Agency Control Number: 18-A-09.

Effective Dates: July 23, 2019, Readoption;
August 19, 2019, Amendments and Repeals.
Expiration Date: July 23, 2026.

Summary of Public Comments and Agency Responses:

The Division of Medical Assistance and Health Services (DMAHS) received comments from: Mr. Steven Novis, Director, Government Relations (Northeast) ViiV Healthcare, and Ms. Pam Wentworth, Administrative Practice Officer, NJ Department of Children and Families.

1. COMMENT: General. Mr. Novis submitted a comment concerning the availability of appropriate antiretroviral (ART) drug interventions for individuals with HIV. He emphasized the need for consistent availability of ART used in the treatment of HIV to ensure that patients maintain adherence to their prescribed treatment regimen. He expressed concerns that changes in circumstances of the beneficiary, for example, income level, may cause fluctuations in eligibility for the Medicaid program and AIDS Drug Distribution Program (ADDP) that may result in those patients living with HIV facing barriers in accessing their medications if they move between sources of coverage. The commenter recommends that the managed care organizations (MCOs) be required to align their antiretroviral formularies to the ADDP program.

RESPONSE: Both ADDP and managed care plans provide access to all medically necessary HIV medications. ADDP is funded through the Federal Ryan White HIV/AIDS Program and operates under separate budget and program specific rules. Managed care plans establish preferred drug lists to assist in obtaining best pricing to ensure consumer access to services. Any medication not available through a preferred drug list can be obtained by a patient through the medical exception process (see N.J.A.C. 10:51-1.27). The Department is unaware of patients living with HIV (PLWH) being declined treatment due to the approaches used to provide coverage for HIV medications. Therefore, no changes will be made in response to the comment.

It is important to maintain access to medically appropriate medication for the treatment of PLWH in order to sustain low viral load levels. Between April 2018 and April 2019, two to three percent of ADDP beneficiaries transitioned monthly to a Medicaid/NJ FamilyCare (NJFC) managed care plan. The managed care plan provides an ADDP beneficiary the full scope of Medicaid/NJFC-covered services.

2. COMMENT: General. Mr. Novis commented that several other states' Medicaid programs have expanded services and programs designed to improve HIV care and quality as measured by viral load suppression (VLS) measures. According to the commenter, Medicaid programs in those states have linked HIV quality measures and measurement of VLS to MCO performance. The commenter recommends that New Jersey expand current HIV services and implement similar incentive programs.

RESPONSE: Providing quality health care and improving the care and quality of all health care services provided to Medicaid beneficiaries is the primary goal of the Medicaid/NJ FamilyCare program. The comment is beyond the scope of this readoption; and therefore, no changes are being made to the rule in response to the comment. The Department reserves the right to explore this recommendation in future policymaking.

3. COMMENT: N.J.A.C. 10:74-1.4. Ms. Wentworth suggested amending the definition of "Child Protection and Permanency (CP&P)" to (1) remove the reference to "adults" because adults can only receive services if they are provided in relation to a child who is under the supervision of CP&P; (2) to more closely reflect the descriptions of CP&P from the Department of Children and Families' website and the statutory definition as set forth by the provisions of P.L. 1951, c. 138 (N.J.S.A. 30:4C-2); (3) to remove the second sentence of the definition and move it to a section in the rules on eligibility; and (4) clarify whether the reference to children in private adoption agencies is to children under the supervision of CP&P.

RESPONSE: The Department agrees with Ms. Wentworth's suggestions and the definition will be changed to be separated into two definitions upon adoption, "Child Protection and Permanency (CP&P)" and "CP&P clients". The definition of "CP&P clients" is being kept in the list of definitions because this chapter does not have a specific subchapter for NJ FamilyCare eligibility. The eligibility requirements for NJ FamilyCare are addressed in N.J.A.C. 10:78 and the eligibility requirements for the NJ FamilyCare-Children's Program are addressed in N.J.A.C. 10:79.

4. COMMENT: N.J.A.C. 10:74-3.3(a)27 and 29. Mr. Novis expressed approval of the fact that the State of New Jersey is addressing substance use disorder (SUD) and recommends that DMAHS refer to the American Society of Addiction Medicine (ASAM) National Practice Guidelines, which recommend testing all opioid use disorder patients for HIV and providing counseling and education regarding HIV to all patients receiving SUD services.

RESPONSE: N.J.A.C. 10:74-3.3(a)27 requires that the MCO provide mental health/SUD services to individuals who are enrolled in Managed Long-Term Support Services, who are clients of the Division of Developmental Disabilities, or who are clients in a Fully Integrated Dual Special Needs Program. Additionally, N.J.A.C. 10:74-3.3(a)29 requires that the MCO provide inpatient SUD services. The MCO arranges for the provision of these by referring the patient to an appropriate treatment. The treatment provider assumes responsibility for determining and providing the specific medically necessary, appropriate services, which may include, but not be limited to, testing, counseling, and education about healthcare concerns associated with SUD. No changes are being made to the rule in response to this comment.

5. COMMENT: N.J.A.C. 10:47-3.4(a)7. Ms. Wentworth commented that CP&P (formerly the Division of Youth and Family Services (DYFS)) no longer operates residential centers or group homes, so the reference to CP&P operating these facilities should be deleted.

RESPONSE: The Department will make the change upon adoption and remove the reference to CP&P at N.J.A.C. 10:74-3.4(a)7.

6. COMMENT: N.J.A.C. 10:74-8.1(b)9 and 8.3(a)6. Ms. Wentworth commented that the term "foster care" should be changed to read "resource family care" pursuant to a change in the terminology. (See P.L. 2004, c. 130.)

RESPONSE: The Department will make the change upon adoption. N.J.A.C. 10:74-8.1(b)9 and 8.3(a)6 will include "resource family care" in place of "foster care."

7. COMMENT: N.J.A.C. 10:74-8.2(a)3i. Ms. Wentworth commented that the reference to a residential facility accredited by DYFS should be deleted because CP&P (formerly DYFS) no longer accredits or operates residential facilities.

RESPONSE: The Department notes that N.J.A.C. 10:74-8.2(a)3i is recodified as N.J.A.C. 10:74-8.2(a)1i as part of this readoption. The requested change to the language will be made upon adoption.

8. COMMENT: N.J.A.C. 10:74-9.1(a)2. Ms. Wentworth requested that the references to N.J.A.C. 10:122D be corrected to read Title 3A because rules related to the Department of Children and Families programs were recodified into Title 3A in 2017.

RESPONSE: The Department acknowledges the outdated references and will make the recommended changes in a future rulemaking.

Summary of Agency-Initiated Changes:

At N.J.A.C. 10:74-3.3(a), the reference to the services listed at "(a)1 through 27" is being changed upon adoption to "(a)1 through 29". The list was expanded and recodified as part of the proposed rulemaking and this change was inadvertently not made at that time.

At N.J.A.C. 10:74-8.2(a)1, the phrase "mentally retarded" is being replaced with "individuals with intellectual disabilities" and the acronym revised to "(ICF/IID)" for consistency with current terminology.

Federal Standards Statement

Section 1932 of the Social Security Act, 42 U.S.C. § 1396u-2, enumerates provisions relating to managed health care services and grants a state Medicaid program the option to use MCOs to provide medical assistance to eligible individuals. New Jersey has elected to provide managed care services to eligible beneficiaries. The statute also elaborates on the choice of coverage by eligible individuals; details the process of enrollment, termination, and change of enrollment; enumerates the rights of beneficiaries; itemizes information that must be given by providers to beneficiaries; spells out protections and sanctions for non-compliance of managed care entities; and assures coverage of medically necessary emergency services.

Section 1903(m)(1)(A) of the Social Security Act, 42 U.S.C. § 1396b(m)(1)(A), defines a Medicaid managed care organization and requires the managed care organization to provide the same access to both Medicaid and non-Medicaid beneficiaries and make adequate provision against the risk of insolvency for a non-governmental entity, and specifies requirements in the managed care organization's contract regarding its financial relationship with a state and the responsibility for managed care payments to beneficiaries.

Pursuant to Section 1915(b) of the Social Security Act, 42 U.S.C. § 1396n(b), a state Medicaid program may secure approval from the Centers for Medicare & Medicaid Services (CMS) for a 1915(b) waiver that would allow that state to limit the choice of providers and require particular groups of beneficiaries to enroll in a managed care plan for medical coverage. New Jersey has secured such a waiver regarding special needs children.

Title XXI of the Social Security Act allows states the option of establishing a State Children's Health Insurance Program (SCHIP) for targeted low-income children and where states elect to utilize the option, provides guidelines for coverage and eligibility. See Sections 2101 through 2110, 42 U.S.C. §§ 1397aa through 1397jj. New Jersey elected this option through implementation of the NJ FamilyCare Children's Program.

Federal standards for a qualified health maintenance organization (HMO) are contained in 42 U.S.C. § 300e-9(c).

Federal standards for MCOs are also found at 42 CFR Part 438. Conditions necessary to contract as a managed care entity (MCE) are specified at 42 CFR 457.955.

The Department of Human Services has reviewed the Federal statutory and regulatory requirements and has determined that the rules readopted with amendments and repeals do not exceed Federal standards. Therefore, a Federal standards analysis is not required.

Full text of the readopted rules can be found in the New Jersey Administrative Code at N.J.A.C. 10:74.

Full text of the adopted amendments follows (additions to proposal indicated in boldface with asterisks ***thus***; deletions from proposal indicated in brackets with asterisks *[thus]*):

CHAPTER 74
MANAGED HEALTH CARE SERVICES FOR MEDICAID/NJ FAMILYCARE BENEFICIARIES

SUBCHAPTER 1. GENERAL PROVISIONS

10:74-1.1 Purpose

The rules in this chapter set forth the manner in which the New Jersey Medicaid/NJ FamilyCare programs shall provide covered health services to eligible persons through the Managed Care program, by means of managed care organizations (MCOs).

10:74-1.2 Authority

(a) The State Medicaid program provides managed medical services under the authority of the New Jersey 1115 demonstration project entitled "New Jersey FamilyCare Comprehensive Demonstration" and under Section 1932(a) of the Social Security Act (42 U.S.C. § 1396u-2(a)).

(b) (No change in text.)

10:74-1.3 Scope

(a) The provisions within this chapter affect Medicaid/NJ FamilyCare beneficiaries.

(b) The rules in this chapter also affect Medicaid/NJ FamilyCare providers, including managed care entities and those providers who will continue to provide certain services on a fee-for-service basis to beneficiaries who are also enrolled in managed care.

10:74-1.4 Definitions

The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise:

…

"AIDS Drug Distribution Program (ADDP)" means the Department of Health (DOH) program, which provides life-sustaining and life-prolonging medications to persons who are HIV-positive, or who are living with AIDS, and who meet residency and income criteria for program participation.

…

"Behavioral health services" refers to the treatment and amelioration of behavioral/mental health conditions, as well as efforts to prevent and intervene in substance use disorder.

…

"Child Protection and Permanency" (CP&P) means the *[component of]* ***child protection and child welfare agency within*** the New Jersey Department of Children and Families (DCF), which ***is responsible for the care, custody, guardianship, maintenance, and protection of children and*** provides comprehensive social services *[for]* ***to ensure the safety, permanency, and well-being of*** children*[,]* ***and*** families*[, and adults]*. *[CP&P beneficiaries who are eligible for Medicaid/NJ FamilyCare are financially eligible children in foster care or other State-supported placements under the supervision of CP&P and children who have been placed in private adoption agencies until they are legally adopted or in subsidized adoptions.]*

…

"Commissioner" means the Commissioner of the New Jersey Department of Human Services or a duly authorized representative.

…

"Comprehensive Waiver" means the New Jersey 1115 Comprehensive Waiver Demonstration that consolidated several previously existing Medicaid waivers for the purpose of:

1. Integrating primary care, acute care, behavioral health care, and long-term services and supports;

2. Providing a wide array of services to individuals with intellectual or developmental disabilities who are living at home with their families;

3. Increasing community-based services for children who are dually diagnosed with developmental disabilities and mental illness by providing case management and behavioral and individual supports; and

4. Expanding managed care to individuals in need of long-term services and supports, diverting more individuals from institutional placement through increased access to home and community-based services (HCBS).

…

"Contractor's plan" means all services and responsibilities undertaken by the contractor pursuant to this chapter concerning managed health care services for Medicaid/NJ FamilyCare beneficiaries.

"County welfare agency (CWA)," formerly known as "county board of social services (CBOSS)," means that agency of county government that is responsible for determining eligibility for certain Medicaid/NJ FamilyCare programs. CWA is the general term for the county agency; depending on the county, the CWA might be identified as the Board of Social Services, the Welfare Board, the Division of Welfare, or the Division of Social Services.

***"CP&P clients" are children who are financially eligible for Medicaid/NJ FamilyCare and are placed in resource homes or other**

State-supported placements under the supervision of CP&P and children whom CP&P has placed in private adoption agencies until they are legally adopted or are in subsidized adoptions.*

…

"Department" means the New Jersey Department of Human Services.

…

"Department of Health" (DOH) means the New Jersey Department of Health.

…

"Disenrollment" means the process of removal of an enrollee from the contractor's plan, not from the Medicaid/NJ FamilyCare programs.

…

"Dually eligible individual" means an individual who is eligible for both Medicare and Medicaid/NJ FamilyCare.

…

"Enrollee" or "enrolled beneficiary" means an individual residing within the defined enrollment area, who elects or has had elected on his or her behalf by an authorized person, in writing, to participate in the specific contractor's plan, whether through the mandatory managed care coverage or on an individual, voluntary basis, and who meets specific Medicaid/NJ FamilyCare eligibility requirements for Plan enrollment agreed to by the Department and the contractor, at N.J.A.C. 10:74-6.

"Enrollment," for the mandatory managed health care program, means the process whereby specified Medicaid/NJ FamilyCare-Plan A beneficiaries are required to join an MCO to receive health services, unless otherwise exempted or excluded. All other NJ FamilyCare beneficiaries, except for certain newborns, are not exempt from mandatory enrollment.

"Enrollment" for the voluntary program means the process by which certain Medicaid/NJ FamilyCare-Plan A eligible individuals voluntarily enroll in an MCO for the provision of health services and by which such application is approved.

…

"Enrollment lock-in period" means the period between the first day of the fourth month and the end of 12 months after the effective date of enrollment in the contractor's plan, during which time the enrollee shall have good cause in order to disenroll or transfer from the contractor's plan. The enrollment lock-in period is not construed as a guarantee of eligibility during the lock-in period. Lock-in provisions do not apply to clients of DDD or SSI, New Jersey Care … Special Medicaid Program—Aged, Blind, Disabled, and CP&P enrollees.

…

"Excluded services" means services covered under the fee-for-service Medicaid/NJ FamilyCare programs that are not included in the managed care benefit package.

…

"Health benefits coordinator (HBC)" means an entity under contract with the Department whose primary responsibility is to assist Medicaid/NJ FamilyCare-eligible enrollees in the selection of and enrollment in a managed care plan.

…

"Health maintenance organization (HMO)" means a public or private organization, organized under State law, which:

1. (No change.)

2. Meets the Division's definition of an HMO, which includes, at a minimum, the following requirements:

i. (No change.)

ii. Makes the services it provides to its Medicaid/NJ FamilyCare enrollees as accessible to them (in terms of timeliness, amount, duration, and scope) as those services are to non-enrolled Medicaid/NJ FamilyCare eligible individuals within the area served by the HMO;

iii. Makes provision against the risk of insolvency, and assures that Medicaid/NJ FamilyCare enrollees will not be liable for the HMO's debts if it does become insolvent; and

iv. (No change.)

…

"Lower mode transportation" means curb-to-curb car or van transportation provided to Medicaid/NJ FamilyCare beneficiaries who are ambulatory and who do not require assistance or supervision to travel to and from their medical appointments.

…

"Managed care organization (MCO)" means an entity that has, or is seeking to qualify for, a comprehensive risk contract, and that is:

1. (No change.)

2. A public or private entity that meets the advance directives requirements of 42 CFR Part 489, Subpart I, incorporated herein by reference, as amended and supplemented, and is determined to meet the following conditions:

i. Makes the services it provides to its Medicaid/NJ FamilyCare enrollees equally accessible (in terms of timeliness, amount, duration, and scope) as those services that are provided to other Medicaid/NJ FamilyCare beneficiaries within the area served by the entity; and

ii. (No change.)

…

"Managed long-term services and supports (MLTSS)" means services that are provided under the New Jersey 1115 Comprehensive Waiver through Medicaid/NJ FamilyCare MCO plans, the purpose of which is to support clients who meet nursing home level of care in the most appropriate setting to meet their specific needs, allowing them to remain at home in the community instead of living in a nursing facility.

1. Individuals qualify for MLTSS by meeting established Medicaid financial requirements and Medicaid clinical and age and/or disability requirements for nursing facility services contained at N.J.A.C. 10:69, 70, 71, or 72.

2. For children who meet the nursing home level of care, and who are applying for MLTSS, there is no deeming of parental income or resources in the determination of eligibility.

3. Once qualified to receive MLTSS, the individual must be enrolled with a managed care organization (MCO) in order to receive MLTSS services.

…

"Marketing" means any activity by, or means of communication from, the MCO, its employees, affiliated providers, subcontractors, or agents, or on behalf of the MCO by any person, firm, or corporation, by which information about the MCO's plan is made known to Medicaid/NJ FamilyCare eligible persons that can reasonably be interpreted as intended to influence the individual to enroll in the MCO's plan or either to not enroll in, or to disenroll from, another MCO's plan.

…

"Medicaid/NJ FamilyCare beneficiary" means an individual eligible to receive services under the New Jersey Medicaid fee-for-service program or any NJ FamilyCare plan in accordance with N.J.A.C. 10:69, 10:70, 10:71, 10:72, 10:78, or 10:79.

"Medically necessary services" means services or supplies necessary to prevent, diagnose, correct, prevent the worsening of, alleviate, ameliorate, or cure a physical or mental illness or condition; to maintain health; to prevent the onset of an illness, condition, or disability; to prevent or treat a condition that endangers life or causes suffering or pain or results in illness or infirmity; to prevent the deterioration of a condition; to promote the development or maintenance of maximal functioning capacity in performing daily activities, taking into account both the functional capacity of the individual and those functional capacities that are appropriate to individuals of the same age; to prevent or treat a condition that threatens to cause or aggravate a handicap or cause physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the enrollee. The services provided, as well as the treatment, the type of provider and the setting, are reflective of the level of services that can be safely provided, are consistent with the diagnosis of the condition and appropriate to the specific medical needs of the enrollee and not solely for the convenience of the enrollee or provider of service and in accordance with standards of good medical practice and generally recognized by the medical scientific community as effective. Course of treatment may include mere observation or, where appropriate, no treatment at all. Experimental services or services generally regarded by the medical profession as unacceptable treatment are deemed not medically necessary. Medically necessary services provided are based on peer-reviewed publications, expert pediatric, psychiatric, and medical opinion, and medical/pediatric community acceptance. In the case of pediatric enrollees, this definition applies, with the additional criteria that

the services, including those found to be needed by a child as a result of a comprehensive screening visit or an inter-periodic encounter, whether or not they are ordinarily covered services for all other Medicaid/NJ FamilyCare enrollees, are appropriate for the age and health status of the individual and that the service will aid the overall physical and mental growth and development of the individual and the service will assist in achieving or maintaining functional capacity.

…

"Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)" means the Federal law (Pub. L. 110-343), which provides participants who already have benefits under mental health and substance use disorder (MH/SUD) coverage parity with benefits limitations under their medical/surgical coverage. Medicaid/NJ FamilyCare managed care organizations are subject to the MHPAEA statute.

"Multilingual" means, at a minimum, English and Spanish plus any other language that is spoken by 200 enrollees or five percent or more of the enrolled Medicaid/NJ FamilyCare population in the contractor's plan, whichever is greater.

…

"NJ FamilyCare Alternative Benefit Plan (ABP)" means the eligibility package that provides comprehensive, managed care coverage to parents of dependent children, and single or married adults without dependent children. The beneficiary must be between the ages 19 to 64 and have an income between the AFDC standard set forth at N.J.A.C. 10:69-10 and 138 percent of the Federal poverty level.

…

"NJ FamilyCare-Plan D" means the State-operated program that provides managed care coverage to uninsured children below the age of 19 with family incomes above 200 percent and up to and including 350 percent of the FPL. In addition to covered managed care services, Plan D enrollees may access certain services that are paid fee-for-service and not covered by MCOs, as specified in this chapter. Plan D enrollees with incomes above 150 percent of the FPL, except American Indians and Alaska Natives (Al/AN) below the age of 19, participate in cost-sharing in the form of monthly premiums and copayments for services, as specified in this chapter.

…

"Non-covered Medicaid/NJ FamilyCare services" means all services not covered under the New Jersey State Plan for the Medicaid/NJ FamilyCare program.

…

"Out-of-area services" means all services covered under the contractor's benefits package included under the terms of the Medicaid/NJ FamilyCare contract that are provided to enrollees outside the defined service area.

"Out-of-plan services" means Medicaid/NJ FamilyCare covered services that have not been included in the contractor's benefits package. These services are provided under a fee-for-service arrangement through the Division to Medicaid beneficiaries and certain NJ FamilyCare beneficiaries who have enrolled in an MCO.

…

"Service area" means the geographic area in which the contractor is obligated to provide covered services for its Medicaid/NJ FamilyCare enrollees under its contract.

…

"Standard service package" means the list of services, and any limitations thereto, which are required to be provided by managed health care providers to Medicaid/NJ FamilyCare beneficiaries. These packages differ by program.

…

"Subcontractor" means any third party who has a written agreement with the contractor to perform a specified part of the contractor's obligations to the State, and is subject to the same terms, rights, and duties as the contractor. A subcontractor shall not subcontract any obligations contained in its written agreement with the contractor.

…

"Target population" means the population from which the initial number of enrollees, not to exceed any limit specified in the contract, will be drawn; that is, individuals eligible for Medicaid/NJ FamilyCare residing within the stated enrollment area and belonging to one of the categories of eligibility for Medicaid/NJ FamilyCare to be covered under the contract.

"Termination" means the loss of Medicaid/NJ FamilyCare eligibility and, therefore, automatic disenrollment of the beneficiary from the MCO.

"Third-party liability (TPL)" means another party or entity, such as an insurance company, which is, or may be, responsible to pay for all or a part of the health care costs of a Medicaid/NJ FamilyCare-Plan A beneficiary.

…

10:74-1.5 Provider lock-in program under managed care

(a) The managed care contractor may implement a lock-in program that restricts its enrollees to a single pharmacy and/or other provider type for a reasonable period of time. The program shall include policies, procedures, and criteria for establishing the need for the lock-in, which shall be prior approved by DMAHS and shall include the following components to the program:

1. Enrollees shall be notified prior to the lock-in and shall be permitted to choose or change providers for good cause;

2. The lock-in restrictions do not apply to emergency services furnished to the enrollee. A 72-hour emergency supply of medication at pharmacies other than the designated lock-in pharmacy shall be permitted to assure the provision of necessary medication required in an interim/urgent basis when the assigned pharmacy does not immediately have the medication;

3. The lock-in restriction shall not apply while the beneficiary is receiving services on an inpatient basis, including, but not limited to, medical and pharmacy services provided in a hospital, rehabilitation facility, or nursing facility. Upon discharge from the inpatient facility, the beneficiary shall resume accessing services from the pharmacy and/or provider previously designated by the lock-in program.

4. Care management and education reinforcement of appropriate medication/provider use shall be provided. A plan for an education program for enrollees shall be developed and submitted to the Division for review and approval;

Recodify existing 4.-5. as 5.-6. (No change in text.)

7. The contractor shall submit quarterly reports on Provider Lock-in participants, as determined by the DMAHS.

SUBCHAPTER 2. CRITERIA FOR CONTRACTING WITH THE DEPARTMENT

10:74-2.1 Contract requirements

(a) The contractor shall:

1.-4. (No change.)

5. Assure that the provider network used for private, commercial business be equally available to Medicaid/NJ FamilyCare enrollees. Such provider network shall consist of hospitals, physicians, dentists, laboratories, and all other providers of services covered under the contract, and shall ensure that the providers meet, at a minimum, all standards of practice and credentialing as required by Title XIX Medicaid and Title XXI of the Social Security Act, and shall maintain a comprehensive network of providers sufficient to meet the needs of the general population within the counties in which the MCO has a certificate of authority to operate;

6.-7. (No change.)

8. Have the organizational and administrative capabilities to carry out its duties and responsibilities, which shall include, at a minimum, the following:

i. A full-time administrator to manage day-to-day business activities of the contractor and to be the responsible contract officer. (This does not require a full-time administrator to be dedicated solely to the Medicaid/NJ FamilyCare contract.);

ii.-iv. (No change.)

9. (No change.)

10. Comply with eligibility requirements of the program, which shall include, but shall not be limited to, enrolling only individuals who are covered under specified Medicaid/NJ FamilyCare categories of assistance;

11.-15. (No change.)

(b)-(d) (No change.)

SUBCHAPTER 3. BENEFITS

10:74-3.1 Scope of benefits

(a) (No change.)

(b) Under the risk contract, all MCO/managed health care contractors shall provide standard service packages as detailed in the managed care contract, which shall exactly equal the services included in the New Jersey Medicaid/NJ FamilyCare program in amount, duration, and scope of services.

(c) (No change.)

10:74-3.2 Responsibilities of the contractor

(a)-(b) (No change.)

(c) The contractor shall provide EPSDT services for all Medicaid/NJ FamilyCare-Plan A enrollees under 21 years of age in accordance with the protocols approved by the Division as follows:

1. Initial and periodic treatments shall be provided. All further treatments indicated shall be provided in an appropriate and timely manner and shall be appropriately documented as specified by EPSDT requirements. The above shall be provided in accordance with EPSDT requirements as specified at 42 U.S.C. § 1396d(r) and 42 CFR 441.50 through 441.62. The above shall be provided for Medicaid/NJ FamilyCare-Plan A beneficiaries only. EPSDT treatment services shall be limited to services covered under the managed care contract for Medicaid/NJ FamilyCare Plans B, C, and D enrollees and services specified under the fee-for-service program.

2. (No change.)

(d) (No change.)

10:74-3.3 Managed care organization (MCO) benefits for Medicaid/NJ FamilyCare-Plans A, B, C, and D enrollees

(a) The MCO shall provide all services required by the managed care contract, including, but not limited to, the services listed in (a)1 through *[27]* ***29*** below and at N.J.A.C. 10:49-5, for all Medicaid/NJ FamilyCare-Plans A, B, C, and D enrollees, with the exception of those services identified as fee-for-service (see N.J.A.C. 10:74-3.4) or excluded from the specific service package under N.J.A.C. 10:74-3.5:

1.-2. (No change.)

3. Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program services:

i. For NJ FamilyCare-Plans B, C, and D participants, coverage shall include EPSDT: medical examinations, dental, vision, hearing, and lead screening services. Coverage includes only those treatment services identified through the examination that are available under the MCO's benefits package for Plans B, C, and D enrollees or as services specified under the FFS program;

4.-8. (No change.)

9. Prescription drugs, including legend drugs and non-legend drugs that are covered by the Medicaid/NJ FamilyCare program and indicated in the managed care contract;

10.-19. (No change.)

20. Durable medical equipment (DME)/assistive technology devices in accordance with existing Medicaid/NJ FamilyCare rules (see N.J.A.C. 10:59);

21.-23. (No change.)

24. Organ transplants, which include donor and recipient costs, except that the Medicaid/NJ FamilyCare fee-for-service program will reimburse for transplant-related donor and recipient inpatient hospital costs for an individual placed on a transplant list while in the fee-for-service Medicaid/NJ FamilyCare program prior to initial enrollment into an MCO;

25. (No change.)

26. Nursing Facility/Special Care Nursing Facility (NF/SCNF) Services—NF/SCNF services shall be covered for all Medicaid, NJ FamilyCare–Plan A, and NJ FamilyCare Alternative Benefit Plan (ABP) enrollees. This covered benefit is limited to rehabilitation services for NJ FamilyCare - Plan B, C, and D enrollees;

27. Mental health/substance use disorder services only for MLTSS enrollees and those enrollees who are clients of the Division of Developmental Disabilities (DDD) or a Fully Integrated Dual Special Needs Program (FIDE-SNP) program;

28. Partial care and partial hospitalization services (except for DDD clients); and

29. Inpatient mental health and substance use disorder treatment services.

10:74-3.4 Fee-for-service program services requiring MCO assistance to Medicaid/NJ FamilyCare-Plans A, B, C, and D enrollees to access the services

(a) The following services shall be provided to Plans A, B, C, and D enrollees through the Medicaid/NJ FamilyCare fee-for-service program and may necessitate contractor assistance to the enrollee (such as, for example, providing medical orders) to access the services:

1. Personal care assistant services (not covered for Medicaid/NJ FamilyCare-Plans B, C, and D unless enrolled in MLTSS);

2. Medical day care (not covered for Medicaid/NJ FamilyCare-Plans B, C, and D unless enrolled in MLTSS);

3. Outpatient rehabilitation services, including physical, occupational, and speech/language therapy;

4. (No change.)

5. Transportation, lower mode;

6. (No change.)

7. Services provided by DHS mental health/substance abuse *[and CP&P]* residential facilities or group homes;

8.-9. (No change.)

10. Prescription drugs (legend and non-legend covered by the Medicaid/NJ FamilyCare program) for the aged, blind, or disabled.

10:74-3.5 Fee-for-service services for Medicaid/NJ FamilyCare-Plans A, B, C, and D enrollees not requiring case management by the MCO

(a) The following services shall be provided to Plans A, B, C, and D enrollees through the Medicaid/NJ FamilyCare fee-for-service program without requiring case management by the MCO:

1. (No change.)

2. Outpatient mental health services for non-DDD clients, non-MLTSS clients, and non-Fully Integrated Dual Eligible Special Needs Program (FIDE-SNP) clients;

3. Outpatient substance use disorder services for non-DDD clients, non-MLTSS clients, and non-Fully Integrated Dual Eligible Special Needs Program (FIDE-SNP) clients:

i.-iii. (No change.)

4. Drugs paid fee-for-service by the Medicaid/NJ FamilyCare program:

i.-iii. (No change.)

iv. Generically-equivalent drug products of the drugs listed above; and

5. Family planning services and supplies when furnished by a non-MCO-participating provider.

(b) The following services shall be provided to NJ FamilyCare beneficiaries enrolled in Plan A and/or the Alternative Benefit Program through the Medicaid/NJ FamilyCare fee-for-service program without requiring case management by the MCO:

1. Intermediate care facilities/individuals with intellectual disabilities (ICF/IID) services;

2. Waiver and demonstration program services; and

3. Division of Developmental Disabilities Community Care Program (DDD/CCP) services.

10:74-3.6, 3.7, and 3.8 (Reserved)

10:74-3.9 General Medicaid/NJ FamilyCare program limitations

(a) The following service requirements and limitations shall apply in the standard service package or capitation payments, even if provided by the MCO:

1. Although services of podiatrists shall be provided, New Jersey Medicaid/NJ FamilyCare does not ordinarily cover routine foot care or treatment of flat foot conditions. These services shall be provided only when medical necessity is determined.

2. (No change.)

3. Elective/induced abortions are not covered under an MCO program but will continue to be paid on a fee-for-service basis by the Medicaid/NJ FamilyCare program.

10:74-3.10 General Medicaid/NJ FamilyCare program exclusions

(a) (No change.)

10:74-3.12 Availability of services

(a) (No change.)

(b) Each contractor shall ensure that no distinctions will be made with regard to quality of service or availability of covered benefits between Medicaid/NJ FamilyCare enrollees under this subchapter and any other parties served by the contractor.

(c) Each Medicaid/NJ FamilyCare enrollee shall be given the choice of a primary care provider who will supervise and coordinate his or her care.

(d) Generally, the contractor shall have only one enrollment area for all Medicaid/NJ FamilyCare parties served, including those served under these regulations. Modifications of such enrollment area for purposes of contracting under this subchapter shall be achieved by means of contract amendment.

SUBCHAPTER 4. MARKETING

10:74-4.1 Marketing

(a) The contractor shall obtain written approval from the Division prior to the commencement of marketing activities, regarding the form and content of the following:

1. Informational and instructional materials to be distributed to inform Medicaid/NJ FamilyCare enrollees of the scope and nature of benefits provided by the contractor;

2. Informational and instructional materials to be distributed to inform Medicaid/NJ FamilyCare enrollees of changes in program scope or administration;

3. Public information releases pertaining to the enrollment of Medicaid/NJ FamilyCare individuals in the contractor's plan; and

4. (No change.)

(b) The contractor shall ensure that:

1.-5. (No change.)

6. None of the contractor's marketing representatives offer or give any form of compensation or reward as an inducement to a Medicaid/NJ FamilyCare beneficiary to enroll in the contractor's plan. However, for marketing purposes, the MCO may offer health-related promotional giveaways that shall not exceed $15.00 per item and non-health-related promotional giveaways that shall not exceed $10.00 per item, the combined total value of both health related and non-health related promotional giveaways shall not exceed $50.00 in the aggregate annually per individual;

7.-8. (No change.)

SUBCHAPTER 5. INFORMATION PROVIDED TO ENROLLEES

10:74-5.1 Information to be provided to the enrollees by the contractor

(a) At such time as a Medicaid/NJ FamilyCare beneficiary signs an enrollment application of an MCO, the contractor shall inform the beneficiary that:

1. (No change.)

2. During this interim period, the Medicaid/NJ FamilyCare-Plan A only enrollee may continue to receive health services under his or her current arrangement as long as he or she retains Medicaid/NJ FamilyCare-Plan A eligibility; and

3. Subject to the termination of Medicaid/NJ FamilyCare eligibility, the disenrollment rules in N.J.A.C. 10:74-7 and the termination provisions in the contract between the contractor and the Department, the initial enrollment period shall extend for one year.

(b) (No change.)

(c) Prior to, but not later than, the effective date of coverage, or as specified in the contract, the MCO shall provide the following in writing to a new enrollee:

1.-9. (No change.)

10. An explanation of how to obtain noncovered MCO services that are Medicaid/NJ FamilyCare benefits.

(d) (No change.)

SUBCHAPTER 6. GENERAL ENROLLMENT

10:74-6.1 Enrollment

(a) Prior to implementation, the contractor shall obtain written approval from the Division of the method of enrollment and the enrollment forms to be used in enrolling Medicaid/NJ FamilyCare beneficiaries. The contractor shall adhere to the enrollment procedures required by the Division and detailed in the MCO contract.

(b) The contractor shall enroll Medicaid/NJ FamilyCare beneficiaries in the order in which they apply, or are assigned by the Division (in those Medicaid/NJ FamilyCare and Plan A cases where a selection is not made) without restrictions, up to contract limits.

(c) Enrollment shall be for the entire Medicaid/NJ FamilyCare "case" (family household).

(d)-(e) (No change.)

(f) Medicaid/NJ FamilyCare-Plan A enrollees shall be subject to a 12-month enrollment lock-in period and may initiate disenrollment/MCO transfer during the first three months after the effective date of initial managed care enrollment and every 12 months thereafter without cause.

(g) All other Medicaid/NJ FamilyCare enrollees (non-Plan A) shall be subject to a 12-month enrollment lock-in period.

(h) Enrollment lock-in shall not apply to beneficiaries who are aged, blind, and disabled, clients of DDD, or to CP&P clients.

SUBCHAPTER 7. DISENROLLMENT

10:74-7.1 Disenrollment

(a) Disenrollment shall occur:

1. Upon death or whenever the enrollee is no longer Medicaid/NJ FamilyCare eligible, unless otherwise specified in the contract;

2. Except for the aged, blind, or disabled populations, whenever the enrollee moves outside of the MCO's enrollment area boundaries. The contractor shall remain responsible for the enrollee's care until the individual or the family/case has been disenrolled from the plan. Moving from the MCO's enrollment area does not negate a plan's responsibility to provide Medicaid/NJ FamilyCare benefits. If a plan is aware that a beneficiary who is not aged, blind, or disabled is residing outside its enrollment area, the contractor shall ask DMAHS to disenroll the beneficiary due to the change of residence;

3. Whenever the enrollee is admitted to a Residential Treatment Center;

4.-5. (No change.)

6. Whenever a Medicaid/NJ FamilyCare enrollee who was determined eligible under NJ FamilyCare-Children's Program attains the age of 19 years;

7. Whenever a Medicaid/NJ FamilyCare enrollee becomes ineligible due to other health insurance coverage; or

8. Whenever a Medicaid/NJ FamilyCare-Plans B, C, or D participant loses program eligibility in accordance with N.J.A.C. 10:79-7.1.

(b) A Medicaid/NJ FamilyCare-Plan A enrollee may elect to disenroll from the contractor's plan at any time during the first 90 days of an initial period of enrollment in an MCO and once every 12 months after the initial period of managed care enrollment without the need to state a cause.

(c) After the first 90-day period and for the remainder of the enrollment period, a Medicaid/NJ FamilyCare enrollee may elect to disenroll, with cause, at any time. Good cause shall be determined on a case-by-case basis, upon notification to the HBC. Good cause reasons may include, but are not limited to, failure of the contractor to provide services to the enrollee, failure of the contractor to respond to an enrollee's grievance, enrollee is qualified for an enrollment exemption, or enrollee has more convenient access to a PCP/APN in another MCO. Such information shall be made available to the enrollee by the contractor MCO and/or the health benefits coordinator.

1. Medicaid/NJ FamilyCare enrollees subject to mandatory enrollment shall transfer to another participating MCO upon disenrollment from a contractor's plan.

(d) (No change.)

(e) Beneficiaries receiving services in or admitted to a long-term psychiatric hospital or facility, or an ICF/IID shall be disenrolled from the managed care entity on the date of admission to the facility.

SUBCHAPTER 8. ENROLLEES

10:74-8.1 Mandatory managed care enrollment

(a) (No change.)

(b) The following Medicaid/NJ FamilyCare-Plan A eligibility groups shall enroll in a managed care organization:

1.-8. (No change.)

9. Children under CP&P supervision in *[foster]* ***resource family*** care.

(c) (No change.)

10:74-8.2 Enrollment exclusions

(a) The following persons shall be excluded from enrollment in the managed care program:

1. Individuals who are institutionalized in an inpatient psychiatric institution, a long term care nursing facility, or an inpatient psychiatric program for children under the age of 21 or in a residential facility including intermediate care facilities for *[the mentally retarded (ICFs/MR)]* ***individuals with intellectual disabilities (ICF/IID)*** with the following exception:

i. Individuals who are eligible through *[DYFS and are placed in a DYFS non-Joint Committee on Accreditation of Healthcare Organizations (JCAHO) accredited children's residential care facility]* ***CP&P*** or individuals in a mental health or substance abuse residential treatment facility are not excluded from enrolling in the contractor's plan;

2. Individuals in the Medically Needy, Presumptive Eligibility for pregnant women, presumptive eligibility for children under the Medicaid/NJ FamilyCare programs, or the PACE Program;

3. (No change in text.)

4. (No change in text.)

5. Full-time students attending school and residing out of the country while in school; and

6. The following types of dual beneficiaries: Qualified Medicare Beneficiaries not otherwise eligible for Medicaid, Special Low-Income Medicare Beneficiaries (SLMBs), Qualified Disabled and Working Individuals (QDWIs), and Qualifying Individuals 1 and 2 (QIs 1 and 2).

10:74-8.3 Voluntary managed care enrollment (allowed and not allowed)

(a) The following individuals shall be excluded from the automatic assignment process but may enroll voluntarily:

1.-5. (No change.)

6. Individuals eligible through Child Protection and Permanency (CP&P) who are not in *[foster]* ***resource family*** care:

i. All individuals eligible through CP&P shall be considered a unique case and shall be issued an individual 12-digit identification number and shall be enrolled in his or her own right.

7. (No change.)

8. Individuals identified as having more than one active eligible Medicaid/NJ FamilyCare number; and

9. (No change.)

(b) (No change.)

10:74-8.4 (Reserved)

10:74-8.5 Coverage prior to enrollment

If the beneficiary needs Medicaid/NJ FamilyCare-Plan A covered services from the date of eligibility prior to the completion of the enrollment process, care shall be given by fee-for-service providers enrolled in the New Jersey Medicaid/NJ FamilyCare program. These providers shall bill Medicaid/NJ FamilyCare under the normal fee-for-service system, in accordance with N.J.A.C. 10:49-8.

10:74-8.7 Protecting managed care enrollees against liability for payment

(a) If a fee-for-service or managed care provider, whether or not a participant in a program administered in whole or in part by the Division of Medical Assistance and Health Services (DMAHS), renders a covered service to a beneficiary of a program administered in whole or in part by DMAHS, including, but not limited to, the WorkFirst NJ/General Assistance, Medicaid/NJ FamilyCare program, the provider's sole recourse for payment, other than collection of any authorized cost-sharing and/or third-party liability, shall be either DMAHS or the MCO with which DMAHS contracts that serves the beneficiary. A provider shall not seek payment from, and shall not institute or cause the initiation of collection proceedings or litigation against, a beneficiary, a beneficiary's family member, any legal representative of the beneficiary or anyone else acting on the beneficiary's behalf unless (a)1 below, or (a)2 through and including 7 below, apply:

1.-7. (No change.)

SUBCHAPTER 9. EMERGENCY SERVICES

10:74-9.1 Emergency services

(a)-(e) (No change.)

(f) The contractor shall pay for all medical screening services rendered to its members by hospitals and emergency room physicians. The amount and method of reimbursement for medical screenings shall be subject to negotiations between the contractor and the hospital and directly with non-hospital-salaried emergency room physicians and shall include reimbursement for urgent care and non-urgent care rates. Non-participating hospitals may be reimbursed for hospital costs at Medicaid/NJ FamilyCare rates or other mutually agreeable rates for medical screening services. Additional fees for additional services may be included at the discretion of the contractor and the hospital.

1.-2. (No change.)

(g)-(k) (No change.)

(l) As required by 42 U.S.C. § 1396u-2(b)(2)(D), all non-participating providers of emergency services including, but not limited to, non-contracted hospitals providing emergency services to Medicaid/NJ FamilyCare members enrolled in the managed care program, shall accept, as payment in full, the amounts that the non-contracted providers and/or hospitals would receive from Medicaid/NJ FamilyCare for the emergency services and/or any related hospitalization as if the beneficiary were enrolled in FFS Medicaid.

SUBCHAPTER 10. MEDICAL INFORMATION AND QUALITY ASSURANCE

10:74-10.2 Quality assurance

(a)-(b) (No change.)

(c) The contractor shall submit to the Division for approval a detailed plan for establishing and maintaining an internal quality assurance system to assure that acceptable professional practice shall be followed by the organization and its subcontractors. This shall include a proposed system for continuing performance review and health care evaluation, that is, explanation of the methods that the contractor proposes to follow in guaranteeing that the services provided each enrollee shall meet criteria established by appropriate Federal and State statutes and regulations. (See 42 CFR Part 438.)

1. The contractor shall include in the written agreement with the subcontractor, the requirement that a subcontractor be prohibited from further subcontracting any of the obligations that they agreed to meet.

(d)-(e) (No change.)

SUBCHAPTER 11. GRIEVANCE PROCEDURE

10:74-11.2 Medicaid/NJ FamilyCare fair hearing

(a)-(c) (No change.)

SUBCHAPTER 12. REIMBURSEMENT

10:74-12.1 Contractor compensation

(a) Compensation to the contractor for MCO enrollees shall consist of monthly capitation payments for each enrollee. These payments shall be for a defined scope of services to be furnished to a defined number of enrollees, for providing the services contained in the Benefits Package as described in N.J.A.C. 10:74-3. Such payments shall be actuarially sound and in accordance with 42 CFR 438.6, incorporated herein by reference, as amended and supplemented. In addition, supplemental fee-for-service payments may be made to the contractor for certain services, which shall be specified by contract in a manner determined by the Division of Medical Assistance and Health Services. In addition, certain high-cost, low-utilized drugs and blood products costs as specified by contract will

be reimbursed to the MCO at the lesser of their cost or the current Medicaid/NJ FamilyCare fee-for-service payment amount.

(b)-(c) (No change.)

SUBCHAPTER 13. GENERAL REPORTING REQUIREMENTS

10:74-13.1 Reporting requirements

(a) (No change.)

(b) The contractor shall submit to the Division at least annually, information specified by the Division on non-Medicaid/NJ FamilyCare enrollees for purposes of comparative analyses of service use and cost patterns.

(c)-(h) (No change.)

TRANSPORTATION

(a)

DIVISION OF RIGHT OF WAY AND ACCESS MANAGEMENT

State Highway Access Management Code

Adopted Amendments: N.J.A.C. 16:47-2.1 and 5.2

Adopted Repeal and New Rule: N.J.A.C. 16:47-Appendix E, Figure E-2

Proposed: May 6, 2019, at 51 N.J.R. 565(a).
Adopted: July 18, 2019, by Diane Gutierrez-Scaccetti, Commissioner, Department of Transportation.
Filed: July 19, 2019, as R.2019 d.087, **without change**.

Authority: N.J.S.A. 27:1A-5, 27:1A-6, 27:7-44.1, and 27:7-89 et seq., specifically 27:7-91.

Effective Date: August 19, 2019.
Expiration Date: July 16, 2025.

Summary of Public Comment and Agency Response:
No comments were received.

Federal Standards Statement

A Federal standards analysis pursuant to Executive Order No. 27 (1994) and P.L. 1995, c. 65, is not required because the adopted amendments, new rule, and repeal come within the authority of State statute only and are not subject to Federal requirements or standards.

Full text of the adopted amendments and new rule follows:

SUBCHAPTER 2. DEFINITIONS

16:47-2.1 Definitions

The following words and terms, when used in this chapter, shall have the following meanings unless the context clearly indicates otherwise. Words in the singular shall include the plural and words in the plural shall include the singular where the context so requires.

. . .

"Adjustment of driveway" means changing the width of the curbline opening of a driveway by five feet or less, changing the location of a driveway by 10 feet or less, moving a driveway away from the centerline of the State highway (such as when the State highway is widened), or changing the elevation or profile of a driveway, in conjunction with a State highway project advanced by the Department or others.

. . .

"Modification of driveway" means changes to driveways in conjunction with the implementation of a State highway improvement advanced by the Department or others, with Department approval, which changes the number of driveways, the width of the curbline opening of a driveway by more than five feet, or the location of a driveway by more than 10 feet. It includes replacing all ingress or all egress between a State highway and a lot or site with ingress or egress via a private easement on a different lot or site; or elimination of ingress, egress, or both between one State highway and a lot or site, while still providing ingress, egress, or both between a different State highway and the lot or site. Modification of driveway does not refer to changes made by a lot or site owner to his or her own driveway.

. . .

SUBCHAPTER 5. CONFORMANCE AND MAXIMUM TRIP LIMITATIONS FOR NONCONFORMING LOTS

16:47-5.2 Trip limitations for nonconforming lots or sites

(a) (No change.)

(b) Maximum trip limitations shall be determined as follows:

1.-3. (No change.)

4. The maximum peak hour trips (V) will be increased by 15 percent (V = 1.15) if a lot or site has features in (b)4i below. No increase in the maximum trip limitations shall be given to any lot created by the subdivision of a nonconforming lot.

i. (No change in text.)